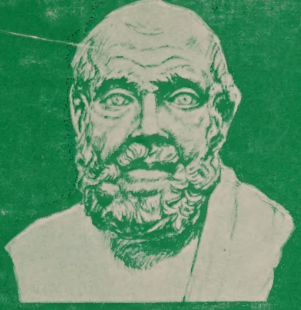
The Hampden Hippocrat



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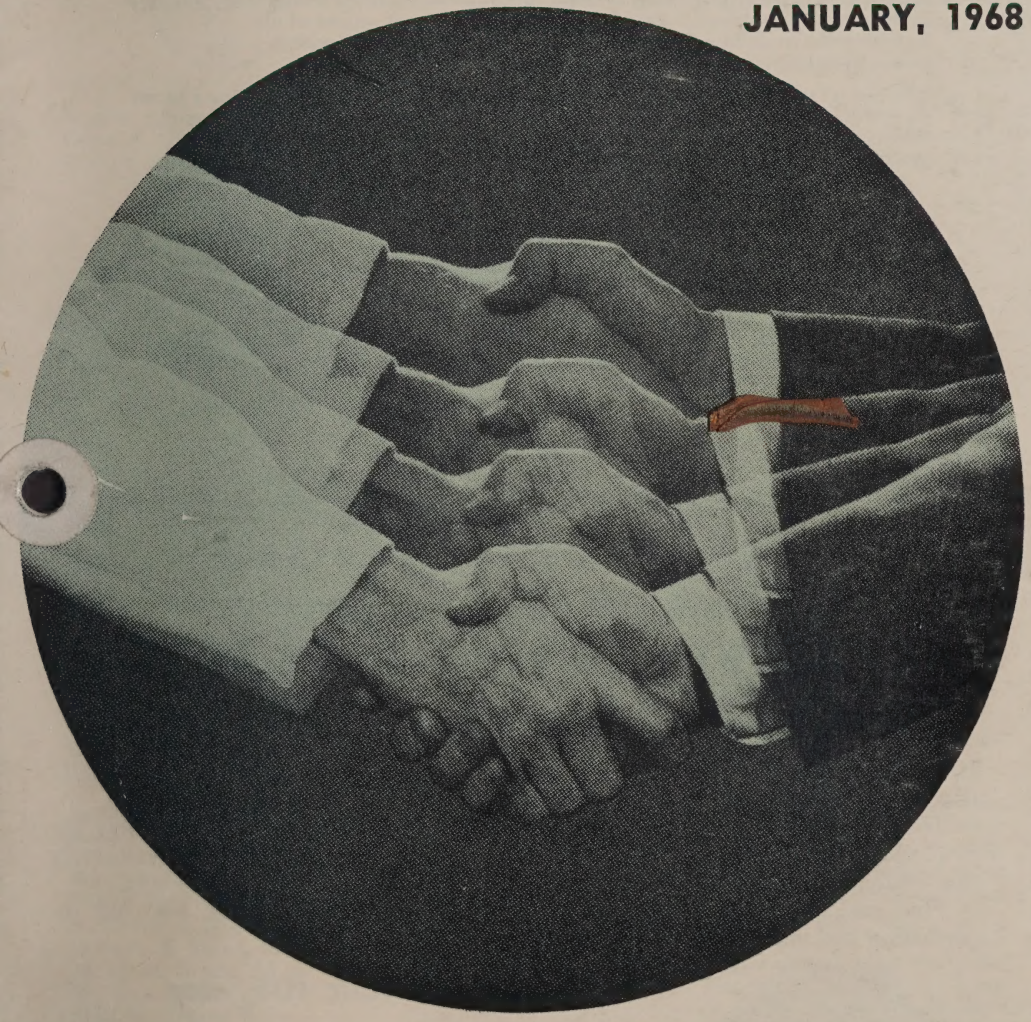

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The Hampden Hippocrat

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EDITORIAL

It's Always P.R. Time

In recent years it has become virtually traditional to devote the January issue of *The Hampden Hippocrat* to the subject of public relations. The new year seems to stimulate introspection and formulation of constructive resolutions which are strongly intended for appropriate fulfillment during the ensuing year. Such seems to be the custom, but there also seems to be associated therewith some elements of passing fancy. Such cannot be the case with public relations, for it's always P.R. time!

Public relations is a rather vague term which is used to describe a conglomeration of practices and activities designed to win the good will and cooperation of people individually and in groups. Not only is the field of public relations difficult to define, but it also is problematical to describe the various factors contributing to it. All too often public relations is equated to publicity. While press releases, public addresses, utilization of various media for mass communication, and the like are of great importance in their place, public relations encompasses far more. It includes every conceivable factor and circumstance that may influence the attitude of people toward an organization, its goals, its program, and its members. It includes most importantly so many seemingly incidental and casual relationships between members of an organization and those served that it might be considered to a large extent the summation of *personal relations.*

Fundamental to a successful program of public relations is the desire to sell the organization — profession in this case — and its program. To accomplish this requires, first of all, a statement of the overall policy of the organization toward the public along with specific aims and purposes. This undoubtedly is what the AMA House of Delegates, meeting in Houston last November, had in mind when it adopted a statement of 11 purposes and responsibilities to more clearly define the overall purpose as written in the AMA's Constitution: "To promote the science and art of medicine and the betterment of public health." (See page 14)

To be effective, a public relations program must be conscientiously planned and constantly watched. Cognizance of all contacts must be taken and arrangements made for their occurrence in a most mutually satisfactory manner. Friendly relationships must be established and maintained with various community groups on the basis of mutual understanding and respect, for these various groups — each with a personality of its own — can serve as most valuable channels for the garnering of good-will and support. Equally as important, every person in an organization or in any way associated therewith must be constantly aware of his or her personal relations with the public — be it a single individual or a group. A slight, a rudeness, or any dissatisfying experience can negate in the mind of an individual favorable regard gained by a carefully planned and carried out program of public relations.

It is thought by some that the purpose of public relations activities is to develop a good cushion of support and defense when the going gets rough. Even though this may be comforting in a time of stress, it is only a fringe benefit for the primary purpose of public relations is to make the road as smooth as possible in the first place.

John C. Ayres, M.D.

NEXT MEETING OF THE HAMPDEN DISTRICT MEDICAL SOCIETY

WIVES INVITED

TIME: FRIDAY, FEBRUARY 9, 1968
Social Hour from 6:30 p.m. to 7:30 p.m.
Dinner at 7:30 p.m.

PLACE: HIGH POINT MOTOR INN on Route 33 just off the Mass. Turnpike, Exit 5

PROGRAM: Entertainment with

(1) "Docs and Their Dolls" as produced by Roger Parenteau, M.D.

(2) Special guest — The Singing Doctor David R. Jackson, M.D., Northampton, Mass.

(3) Dancing until 1:00 a.m.

RESERVATIONS: Must be made in advance—deadline, February 7, 1968—and must be accompanied with a remittance of $10.00.

John F. Griffin M.D.

JOHN F. GRIFFIN, *Secretary*

PUBLIC RELATIONS – 1968

BERNARD BLOOM, M.D.

Chairman, Public Relations Committee

The image of the physician continues to tarnish steadily with exposure to the daylight of public scrutiny. Whereas, the majority of physicians are hard working, conscientious, and skillful in their professional activities; the unpleasant situations created by a very few reflect on the entire profession. The glamour associated with the family physician of years ago is gone forever. It has been captured by the DeBakeys, the Professor Christian Barnards, the Sabins, the Salks, and their ilk.

The practicing physician on the community level is expected to render service in an efficient, knowledgeable, and satisfying manner at any and all times. Since he has become affluent, as have many other professional groups, the public now finds many reasons with which to bate him. The increasing cost of medical care, particularly in relation to hospital services, is laid at the doorstep of the medical profession. Not as much is said of the slow rise in medical fees, which is in keeping with the increased cost of living. On the other hand, much is made of the meteoric rise in hospital costs, particularly, in reference to serious and prolonged illnesses, with the blame being laid chiefly on physicians as a group. Mention is not made of the more rapid recovery from illness or the lower morbidity and mortality due to the availability of modern therapeutic and diagnostic methods. The physician is a silent hero when by the proper, judicious, and timely application of his hard-earned knowledge he brings a patient back to health. It is difficult to explain these concepts to patients and critics, and we must be content with the satisfaction which follows a job well done.

How do we avert or arrest this steadily deteriorating image of the physician? Not a week goes by without there appearing a new book, magazine article, or press release criticizing some facet of medical practice. The Medicare *hullabaloo* has died down to some extent because the medical profession has made it work, only to be followed by almost daily criticism in the press of the physician and his involvement with Medicaid. Until this social revolution in medical care has run its course, the physician must fortify himself to withstand these incessant assaults.

Where can he help the situation? Everywhere that he is in communication with the public at large and with his patients in particular. This means solicitous considerateness of patients in the office, at the hospital, on house calls, and in every area of the community. The doctor lives in a glass house vulnerable to every whim of those alienated against him. Constant alertness and vigilance to render good service, at a fair fee and in a sympathetic manner will go a long way toward improving the doctors' public relations.

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THE PHYSICIAN AND HIS IMAGE – 1968

by JOHN W. TURNER, M.D.

The mainstream of American medicine continues in the traditional efforts to conquer all man's physical and mental ailments. As a profession, we consistently strive to control and suppress reasons for our existence—disease.

There is still a profound mutual regard between the sick patient and the physician when contact is direct and sustained. Misunderstanding and loss of mutual respect are enhanced by interposition of third parties. Most medical arguments in recent decades have been not between physicians and patients but, rather, between physicians and governmental agencies or physicians and other third party constituents.

Patients still respond to courtesy, consideration and being treated as individuals rather than as registration numbers. In this latter role, we, in the Hampden District, have an advantage over the impersonal thousand bed hospital milieu. This advantage of ours should be ever in the forefront of our consciousness.

As recent decades have passed, work of high merit has been performed in our community hospitals. The excellent tumor surgery, chest surgery, neurosurgery, cardiology and general medical care now available within the Hampden District were not equally extant years ago. It is appropriate that we as physicians use every opportunity to emphasize this remarkable difference to the lay public. Often the most effective method to achieve this is to describe in general terms the fine accomplishments of fellow physicians. The power of positive thinking is something to consider. Many positive gains in medicine can be related by another physician though left unsaid by the physician who replaced the aorta or removed the lung or saved the coronary patient. I saw a patient today who had a total gastrectomy thirteen years ago and was reminded that on the same day's operating schedule other surgeons did a hind quarter amputation for sarcoma of the proximal end of the femur invading the acetabulum and on that day a neurosurgeon successfully removed a cerebello-pontine angle tumor.

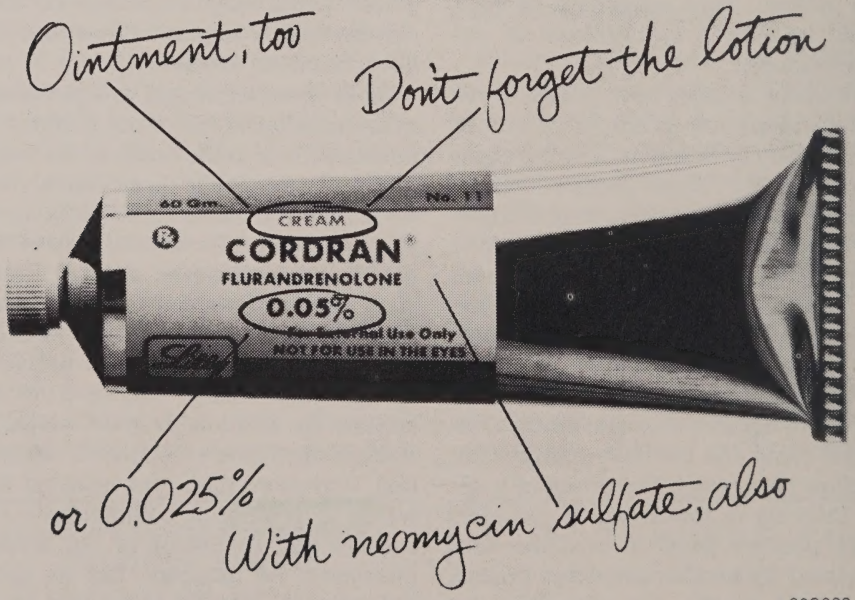
Patients have become conditioned to think medically by an ever increasing amount of medical information in press, radio and television presentations. It behooves us as a profession to guide this interest. This seems sufficient reason to lend support to the efforts of our Public Relations Committee in providing speakers on different specialities and subjects as needed.

Further, in the busy activity of our professional lives, we should use more often the mechanism of writing crisp, informative letters to editors on both medical and socio-economic problems. These reach large numbers of individuals with a minimal effort and can have excellent results.

In 1968 we are caught as a profession in an inflationary spiral not initiated by medicine. It is to the credit of the medical profession that professional fees have followed rather than led a rising cost and that professional fees have lagged far behind hospital charges. In our daily efforts, if we can maintain a sincere and energetic attitude of concern for patients, many of the other problems of medicine's image will tend to disappear. In addition to good works, to counter medicine's vociferous opposition, it is more than ever essential that we as a profession communicate our concern and something of our accomplishments for patients. Let us speak well of each other as physicians. Much that is good is being accomplished for patients.

HOUSTON – 1967

The need for *positive leadership* and *visible action* by the medical profession and all other members of the health team was the call issued by Milford O. Rouse, M.D., President of the AMA, to the House of Delegates meeting at the 21st Clinical Convention in Houston, Texas, from November 26th to the 29th. And plenty of positive action ensued therefrom. The House of Delegates dealt with 96 items of business including 17 reports from the Board of Trustees, 20 from the four Standing Committees of the House, one special report from the AMA-ERF and the Commission to Coordinate the Relationships of Medicine with Allied Health Professions and Services, and



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For brief summary of prescribing information, see reverse side.

Prescribing Information

Indications: "Symmetrel" is indicated for the prevention (prophylaxis) of influenza A_2 in persons of all age groups. Early use is recommended, preferably before or as soon as possible after actual or suspected contact with individuals suffering from influenza A_2. "Symmetrel" should especially be considered for high influenza-risk patient groups such as those suffering from chronic debilitating diseases and elderly persons.

Contraindications: Not indicated for the prevention of influenza or respiratory disease other than influenza A_2 or for the treatment of established illness. Availability of "Symmetrel" should not affect the physician's usual vaccine practices.

Warnings: Administration to patients with central nervous system disease, particularly geriatric patients with cerebral arteriosclerosis, and patients with a history of epilepsy or other "seizures", requires strict observation for possible untoward effects (see Adverse Reactions). Patients taking psychopharmacologic drugs, central nervous system stimulants, or alcoholic beverages should be observed for possible evidence of intolerance. Those patients who experience central nervous system effects or blurring of vision should be cautioned against driving or working in situations where alertness is important.

No teratogenic effects have been seen in reproductive studies in rats and rabbits. Studies in pregnant women have, however, not been done and use of this drug in women of childbearing age should be undertaken only after weighing the possible risks to the fetus against benefit to the pregnant patient. It should not be administered to nursing mothers since it is not known whether the drug is secreted in the milk.

Precautions: Ineffective against bacterial infections. Patients should be observed for idiosyncratic reactions as with all new drugs. Geriatric patients with pre-existing serious medical illnesses with mental or physical deterioration should be followed carefully while taking "Symmetrel". (See Adverse Reactions.)

Adverse Reactions: With higher than indicated doses manifestations of central nervous system effects such as nervousness, insomnia, dizziness, lightheadedness, drunken feeling, slurred speech, ataxia, inability to concentrate and some psychic reactions including depression and feelings of detachment were seen. Occasional blurred vision was reported at higher doses. Some of the milder and less pronounced symptoms above have been reported in a small number of patients taking the recommended dosage of 200 mg per day. These were mostly transient and disappeared with continued administration of the drug. Some geriatric patients developed paranoid or hallucinatory behavior and became unmanageable while taking 200 mg daily. Medically unselected seriously deteriorated geriatric patients showed poor clinical tolerance after several weeks of daily dosing with 200 mg per day. One elderly patient with a history of prior cerebrovascular accident developed visual hallucinations and grand-mal convulsions while on the drug at 800 mg per day. Some cases of dry mouth, gastrointestinal upset and skin rash and, rarely, tremors, anorexia, pollakiuria, and nocturia have been also reported.

Dosage: Adults: Two 100 mg capsules (or 4 teaspoonfuls of syrup) as a single daily dose; or the daily dose may be divided into one capsule of 100 mg (or 2 teaspoonfuls of syrup) twice a day.

Children: 1 yr.—9 yrs. of age: Calculate total daily dose on the basis of 2 mg to 4 mg per pound of body weight per day (but not to exceed 150 mg per day). Daily dose, given as the syrup, should be given in 2 or 3 equal portions.

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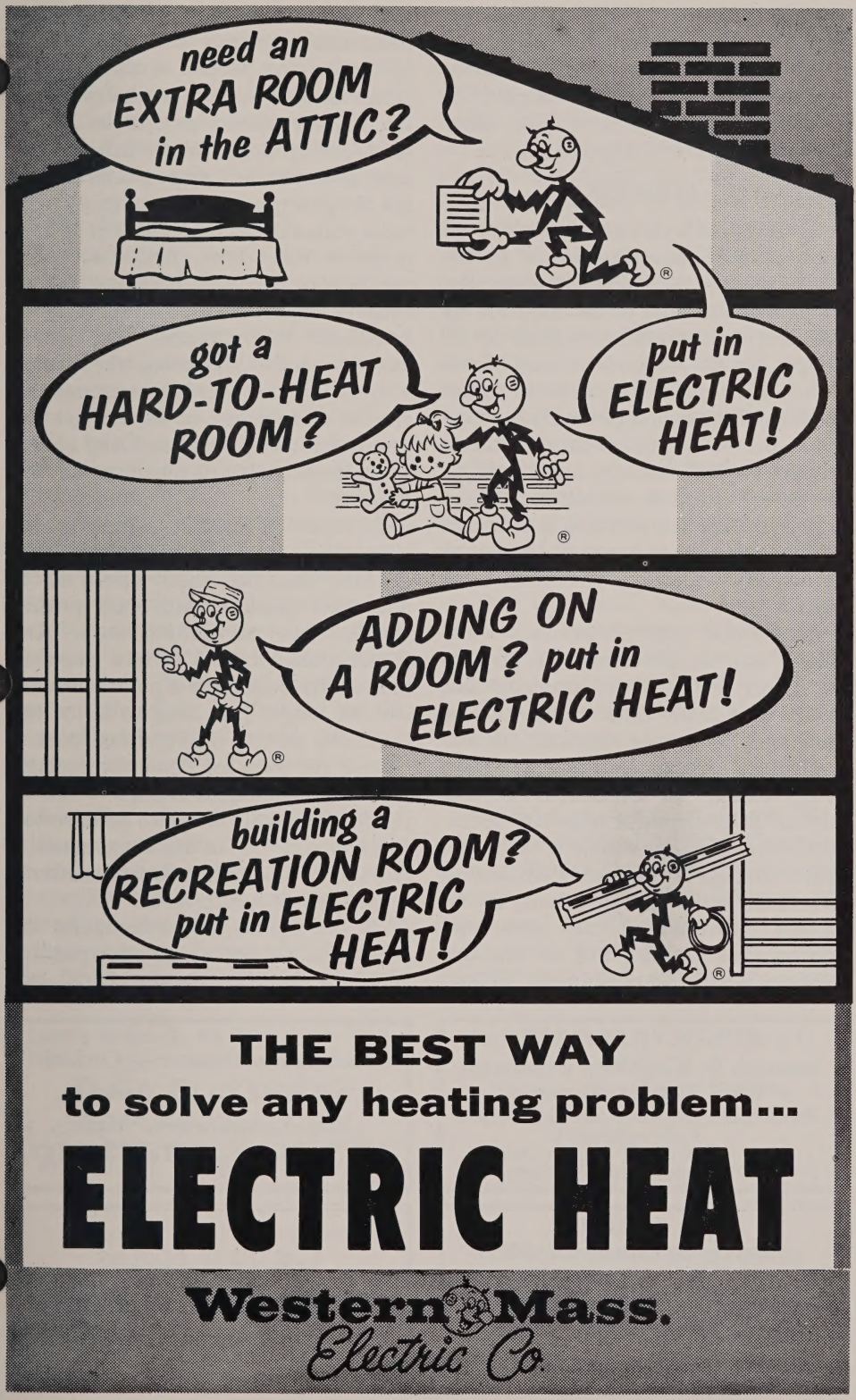
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57 resolutions from state medical societies as well as individual physicians. Of these, the House adopted 43 without amendment; amended and adopted 22; referred 21; absorbed 4 into other adopted items; and rejected 6.

KEYNOTE ADDRESS

During Sunday's opening session on November 26, President Rouse stated: "The future of the individual physician, of patient care and of the methods by which it will be made available to all people do not depend on our efforts alone. They depend also on the future attitude of the nation toward free enterprise; on the degree of future national respect for individual initiative; and on the extent of future over-all acceptance of the concept that personal satisfaction and personal benefit are to be gained principally through personal endeavor."

Dr. Rouse pointed out that many things can be done only by government, or best by government, but added that many other things can be done only by private organizations and individual citizens working together. The reason, he explained, is that actions of government often are necessarily negative. For example, "Government can pass laws against theft, but no law can make people want to be honest. Government can pass laws against drunkenness, but no law can make a people want sobriety." However, he added, "Leaders in government understandably see it as their duty to do for the people of this country whatever they believe, or whatever they are told by citizen groups, is not already being done. When private citizens abdicate their responsibilities and ask the government to do a job, government responds in the only way it can: it passes more laws. And every time another law is passed, it means another small or large restriction on somebody's freedom." "As citizens," Dr. Rouse said, "we have this choice when facing a situation that needs correcting: we can do it ourselves; or we can ask the government to pass a law" and set up an administrative mechanism to enforce it.

In regard to specific, current problems—the cost of health care and the growing need for more effective cooperation among health care professionals and sub-professions — Dr. Rouse stated that "I believe sincerely that we have reached a point when we can no longer just cling to all of the traditions of our distinguished past. I believe the time has come for orderly, planned, meaningful change — not in the fundamentals of ethics or devotion to excellence but in the more material features of efficiency, cost and methods of delivery of health care."

"If we should fail to recognize the present as an opportunity for positive action, I believe we would fail not

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"Let us not make it necessary," he concluded, "for anybody else to direct the furnishing of those services."

MEDICAL EDUCATION

Several actions were taken relating to medical education. One was the adoption of the Board of Trustees' summary of the Report of the Commission on Research. Fifteen recommendations were contained in the Commission report, two of which were seen as particularly significant. Recommendation 12 encouraged research in the delivery of health care, "provided it is conducted under proper auspices and in accordance with sound research design and methodology." The House adopted it, with the understanding that such support "should not be interpreted to imply any criticism of the present studies of the delivery of health care." Present efforts are productive, but the medical profession "should not hesitate to make known its interest in continued studies to improve the methods and quality of health care delivery."

Recommendation 13 was addressed to correcting the imbalance between biomedical research and education caused by the "heavy but desirable federal support of research." It stated that "there should be allotted a greatly increased amount for operational expenses of medical schools, to be matched by those schools through private or local governmental sources." Again the House concurred, stressing the fact that its approval of the recommendation changes the policy of the AMA with respect to federal support for medical education. The change results in "an honest recognition that federal financial support is now accepted by the American medical schools." However, in adopting the recommendation, the House "emphatically urges that a matching formula be used" to "encourage medical schools to retain their independence."

The House also adopted a resolution that the AMA, through its Council on Medical Education, "utilize all appropriate influences to restore teaching to its proper place of prominence in medical education" instead of giving the lion's share of attention, honors and contributions to research scientists; and adopted 12 guidelines for medical staffs in hospitals with intern and resident training programs.

HEALTH MANPOWER

A report was adopted on the "Report of the National Advisory Commission on Health Manpower," which was submitted to President Johnson on November 20. The report was necessarily brief, since there had not been time to study and evaluate the Com-

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mission report in any depth, but it pointed out that the Commission's approach to health care problems indicated recognition of the need for orderly procedures rather than harmful "crash" programs. The emphasis in most of the Commission report is to center responsibility on the professional groups best able to evaluate and plan in health areas, rather than on government and non-professionals.

The House adopted the preliminary report; voted to enlarge the AMA Committee on Health Manpower by four members to permit more careful and complete study in this area; and noted that copies of the complete Commission report will be sent to all Delegates and Alternates, requesting them to submit their comments to their constituent associations as soon as possible.

In addition, the House approved replacing the present AMA Commission to Coordinate the Relationships of Medicine with Allied Health Professions and Services with a new council of the Board of Trustees to be known as the Council on Allied Health Professions; and directed the AMA to seek the establishment of a medically oriented federal Commission on Health Resources and Medical Manpower to assure properly balanced distribution of health personnel among government agencies, the armed forces and the civilian population.

Also with respect to health personnel, both professional and allied, the House asked that a report be made at the next meeting evaluating the foreign resident, intern and physician program; requested a study of the present professional liability implications in the use of allied medical personnel; and urged physicians to become acquainted with the program of the American Association of Medical Assistants and to encourage their assistants to participate in its educational and certification programs.

HEALTH CARE

The House adopted a number of reports and resolutions relating to health care from the standpoint of the community and the individual patient.

One emphasizes that standards of medical care are set at the local level and calls attention to disturbing trends pointing to the possible establishment of medical care standards on a national basis.

Another commits the AMA to leadership in informing the public, the profession and other elements of the health care field as to practical means of moderating health care costs, the value of voluntary health insurance, expanding the medical manpower supply and improving the health care of the American people.

With respect to comprehensive planning of health facilities and services,

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the House urged state and local medical societies to emphasize a variety of activities to be undertaken in the area of over-all planning for governmental and private programs of health care, including "continued effort by the medical profession to improve federal legislation in this area and to emphasize the importance of local control."

The House reaffirmed that the procurement, processing, distribution or use of human blood and other human tissue is a medical service and is not the selling of a commodity. The Board of Trustees and the state associations were urged to support legislative action at federal and state levels to implement this concept.

The use of monitoring, defibrillation and resuscitative equipment by registered nurses in cases of cardiac emergencies was supported, with provisions regarding the nurse's training and the procedures established by the hospital medical staff.

MEDICARE AND MEDICAID

In regard to Medicare, the House reaffirmed its support for direct billing under the federal program and adopted a resolution regarding the collection and public dissemination of figures on the administrative costs of Medicare.

The House resolved that the AMA continue its efforts to provide for the implementation of Title 19 in a manner which recognizes "the physician's right to bill directly all patients, including Title 19 patients, and allows the physician or his patient to be reimbursed his usual, customary and reasonable fee for his professional services;" and that the AMA actively seek changes in the law that will secure "equal and simultaneous application to all jurisdictions."

HOSPITALS

Because both Medicare and Medicaid provide payment for medical care rendered to patients by residents, the House resolved that the AMA should study the problem and develop guidelines that are acceptable to supervising physicians, teaching institutions and government agencies involved in the payment process.

In addition, with respect to hospitals, the House adopted resolutions:

(1) proposing the acceptance of physicians on hospital Boards of Trustees as the most effective form of liaison between the medical staff and hospital governing authorities;

(2) protecting hospital privileges through "due process;"

(3) calling for more effective liaison and better coordination between medical staffs and local medical societies;

(4) pointing out the need for simplifying attendance requirements for maintaining membership on hospital medical staffs;

(5) pressing for prompt revision of the JCAH ruling on the use of externs

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in non-university affiliated hospitals, with the incorporation of adequate safeguards to insure the quality of programs of extern education.

In addition, model articles of incorporation for hospital medical staffs were made available for distribution in response to requests.

AMA ORGANIZATION AND PROCEDURES

A number of changes were made in the Bylaws:

(1) Chapter XIV, Section 3(D) was updated, providing that four trustees will be elected annually, each for a three-year term and each limited to three terms.

(2) The terms in office of the President, President-Elect and Vice President all will begin and end at the close of the final session of the House of Delegates at the Annual Convention.

(3) Resolutions must be introduced to the House by a voting delegate.

(4) Nominations for Affiliate Membership in the AMA in classes (3), (4), (5) and (6) must be approved by the appropriate county and state medical society.

(5) A general officer's position is to be considered vacant if he misses six consecutive regular meetings of the Board.

(6) The House approved giving the Vice President voting rights on the Board.

The House adopted a statement of 11 purposes and responsibilities for the AMA, designed to define more clearly the over-all purpose as written in the Constitution: "To promote the science and art of medicine and the betterment of public health."

The entire statement follows:

The Purposes and Responsibilities of the American Medical Association

It is the responsibility of the American Medical Association, as the representative of the American medical profession, to continue to foster the advancement of medical science and the health of the American people.

Its continuing purposes are to meet this responsibility through the following means:

1. By encouraging the further development of medical knowledge, skills, techniques and drugs; and by maintaining the highest standards of practice and health care.

2. By creating incentives to attract increasing numbers of capable people into medicine and the other health-care professions.

3. By advancing and expanding the education of physicians and other groups in the health-care field.

4. By motivating skilled physicians who have the art of teaching to apply themselves to developing new generations of excellent practitioners.

5. By fostering programs that will encourage medical and health personnel to serve voluntarily in the areas of need for medical care.

6. By developing techniques and practices that will moderate the costs of good medical and health care.

7. By seeking out and fostering means of making all health-care facili-

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ties — physicians' offices, hospitals, laboratories, clinics and other — as efficient and economical as good medical practice and attention to human values will permit.

8. By combining the utilization of the latest knowledge for prevention and treatment with the vital healing force of the physician's personal knowledge of and devotion to his patient.

9. By maintaining the impetus of dedicated men and women in providing excellent health care by preserving the incentives and effectiveness of unshackled medical practice.

10. By maintaining the highest level of ethics and professional standards among all members of the medical profession.

11. By continuing to provide leadership and guidance to the medical profession of the world in meeting the health needs of changing populations.

ADDITIONAL ACTIONS

The House approved the action of the Board of Directors of the AMA-ERF and endorsed "in principle" the relocation of the Institute for Biomedical Research "on or contiguous to the University of Chicago campus".

At the same time, the House requested the Board of the AMA-ERF "to present at each Clinical Convention a report on the projected budget of the Institute for Biomedical Research for the ensuing year and the amount of the projected contribution from the AMA to the Institute during that period."

The House adopted recommendations that the AMA arrange a meeting of state medical association representatives to plan regional conferences of physicians to discuss matters of special interest to state legislators; and that state associations invite key lawmakers to attend AMA conferences.

Also approved was a resolution that state associations establish active legislative task forces at the congressional district level to maintain an effective working relationship with congressmen.

The House reiterated its serious concern with respect to the Blue Cross Association's request for government funds for its research project on group practice.

Criteria for the evaluation of medical programs of national voluntary health agencies were adopted.

Three resolutions, referred to the Board, pointed out that many news stories criticizing the rising cost of health care place all or most of the responsibility squarely on physicians. As one of the resolutions put it, "Statistical reports relating to health care costs are misleading when they are referred to . . . as medical care costs; and . . . the improper labeling . . may actually delay proper analysis of the several components."

Hayes

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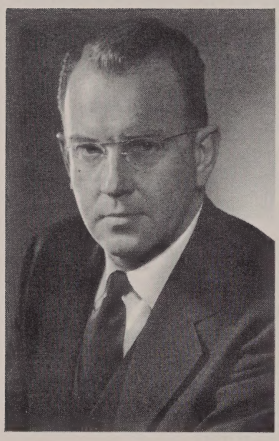

SPEAKER: DWIGHT E. HARKEN, M.D.
Chief, Dept. of Thoracic Surgery
Mt. Auburn Hospital
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HDMS MEETING, FEBRUARY 9

HDMS EXECUTIVE COMMITTEE MEETINGS, FEB. 20 and MARCH 19

MMS COUNCIL MEETINGS, BOSTON, FEB. 7 and MAY 20

AMERICAN ACADEMY OF ALLERGY, BOSTON, FEB. 3 - 7

AMA, SECOND NATIONAL CONGRESS ON THE SOCIO-ECONOMICS OF HEALTH CARE, CHICAGO, ILL., MARCH 22 - 23

AMERICAN PSYCHOSOMATIC SOCIETY, BOSTON, MARCH 29 - 31

MMS ANNUAL MEETING, BOSTON, MAY 21 - 23

AMA ANNUAL MEETING, SAN FRANCISCO, CALIF., JUNE 16 - 20

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WHITHER ACADEMY?

During the first 70 years of its existence, the Hampden District Medical Society (organized 1840) catered to all the needs of the profession. It concerned itself not only with the ethical and socioeconomic problems of the day but also with the post-graduate education of its membership. This usually consisted of two or three lectures a year, delivered in the earlier decades by local "essayists" and later by out-of-town speakers, almost always from Boston. Except for a few ancient, dust-collecting medical volumes on the top floor of the Springfield Public Library, no medical library in the true sense of the word ever existed in this area.

THE ACADEMY IS BORN

Shortly after the turn of the century, however, the need for additional post-graduate facilities became apparent. To meet this demand a group of forward looking physicians organized The Springfield Academy of Medicine (incorporated, March 27, 1907). In the years that followed, the District Society concentrated more and more on non-clinical matters while the job of educating the physician gradually came under the exclusive aegis of the Academy. Of this job the Academy has acquitted itself most nobly and admirably. During the 60 years of its existence, it organized dozens of clinical conferences and sponsored hundreds of guest speakers of great reknown. In addition, it established and developed a medical library which, next to the Boston Medical Library, has become the finest in the Commonwealth. The Academy Library, as we all know, serves not only our profession but also industry, business, and the numerous educational institutions of Western Massachusetts. It need hardly be stressed that the Academy has always had the moral support of the District Society; that the two organizations have always worked most amicably side by side; that they often cosponsored health projects; and that the memberships of the two organizations have always overlapped.

The system of two societies complementing one another and each dealing with a different phase of organized medicine, worked quite satisfactorily for more than half a century. More recently, however, the fortunes and popularity of the Academy have slipped significantly. Attendance at meetings has fallen off sharply and membership has failed to keep pace with the growth of the medical community. Briefly, not enough new members have come in of late to replace those who have faded from the scene. The result is that whereas a decade ago the Academy counted 350 members (see *The Hampden Hippocrat*, October, 1957), today the figure approximates 225.

FISCAL DIFFICULTIES

The crisis confronting the Academy is reflected most poignantly in its fiscal difficulties. Years ago the Academy was completely self-sustaining. Membership dues alone provided then sufficient funds to cover its entire budget including that of the library. Early in the 1950's, however, the Academy found itself in such financial straits as to invite support from business and in-

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dustry. Thus the system of sustaining library membership came into being. This relieved the situation somewhat, but only temporarily. A few short years later the Academy felt called upon to seek additional support outside its membership. This time several generous drug manufacturers came to the rescue. In essence, then, the Academy today receives its economic sustenance from three different sources: (a) membership dues, (b) sustaining library memberships, and (c) drug house sponsorship.

There is, of course, nothing wrong with receiving outside support provided it comes from private or non-government sources. We must realize, however, that no amount of outside support can begin to compare with the wholehearted support that can come from our own profession. Wider professional participation would not only enhance the quality of the post-graduate education but would also provide the necessary dollars and cents. Anyone who has ever served on the Academy's Board of Directors is familiar enough with the difficulties of organizing a decent meeting within the narrow limits of a skimpy budget. Moreover, we must realize that post-graduate education, like everything else, has become much more expensive of late. Whereas, in the dim past guest speakers customarily offered their services free (except, perhaps, for travel expense), today they expect just remuneration for their time and effort.

The reasons offered for the Academy's recent decline in popularity are too well known to require cataloguing: "Too many meetings at the hospitals." "Academy's lectures are outside my specialty." "I'm too busy to attend." "The programs are not interesting enough," etc. Experience has shown that the more interesting the topic and the more renowned the speaker, the better the attendance. Well rounded panels (of the type scheduled for April 20th) attract the largest audience but are also the most expensive. Unfortunately the only time we can afford nowadays a decent panel is when it is sponsored by a drug house.

Has the Academy outlived its usefulness? Certainly not! It is universally agreed that at no time in the history of medicine was the need for continued medical education as great as it is today. To destroy, or to even curtail, the Academy's activities, is therefore unthinkable. In the absence of a medical school in our midst the least we can do is to provide a first rate post-graduate facility centered, most logically, around the Academy. Hospital conferences are indispensable, of course, but tremendous need exists also for other and even more comprehensive programs, programs that would benefit all,

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including the non-affiliated physicians in the area. And finally, even the library alone constitutes sufficient reason for the perpetuation of the Academy of Medicine.

ACADEMY DWELLINGS

During the first six years of its existence the Academy met in four different places: The Cooley, Highland and Kimball hotels and Harmony Hall. In 1913, the Academy, incredible as it may sound, purchased a home of its own, at 349 State Street. Finding it difficult to finance this venture, it sold the property three years later to Dr. Fred Brigham. Next we find the Academy operating at 137½ State Street. In the minutes of April 12, 1927, there appears for the first time a notation by the Secretary of a meeting held at 20 Maple Street, where the Academy was to remain for more than 20 years. In 1948, the Academy began to meet at the Women's Club. In October of 1953, it was voted to move to the Municipal Hospital, and in September of 1954 the first meeting was held in its beautiful auditorium.

The present location of the Academy can hardly be improved upon. The library quarters are modern and spacious. The lecture hall, located under the same roof, is in the words of a recent speaker, "the best he has ever seen for a doctors' gathering." Furthermore, the Academy office and library adjoins the HDMS headquarters — all located in the setting of a hospital. Parking facilities are ample. Because of a substantial initial investment in the construction of the Academy, it occupies its present quarters on a one-dollar-a-year rental basis.

The main reason for reviewing the Academy situation at this time is the resolution presented at its December meeting that the Academy "accept the offer of the Springfield Technical Institute to house the library." The idea of uprooting the Academy library from its present medical environment and transferring it to the domain and premises of a governmental academic agency is objectionable not only to the author but also to a majority of those interviewed. A few dollars may be saved, but in the long run the quality of the library stands to suffer considerably. It is fair to suspect that before long the emphasis will shift from professional journals to quasi-medical textbooks. It is fair to suspect also that sooner or later the State will completely take over. History shows that, whenever we falter in our professional responsibilities, some governmental agency is always apt to take command.

THE REMEDY

The first requisite for a more vital Academy is a 100% membership; everything else is secondary. Experience elsewhere has shown that the only way to accomplish total Academy membership is through affiliation with its local District Society. In some communities (i.e. Worcester) such affiliation has existed for many years. In others, (i.e. Wilkes-Barre, Pa.) the merger of Academies and District Societies took place more recently. It seems incongruous indeed that while all of our 500 District members lend support to The Boston Medical Library (via MMS dues), only a fraction of this number bear the brunt of financing the Academy and its library!

The final decision, needless to say, rests with the Academy membership. In the meantime it is sincerely hoped that its leadership will not only study the Academy problem from all angles but will also encourage the rank and file members to express their views and opinions. Finally, it is hoped that the idea of transferring the library to the Institute be postponed, to say the least. A move of this type will cure none of the intrinsic ills of the Academy and may seriously jeopardize the quality of its library. Millman

DECEMBER MEETING HIGHLIGHTS (Dec. 5, 1967)

The December meeting of the HDMS was held at the Storrowton Tavern, Stage Coach Barn, West Springfield, with President Baker calling the meeting to order at 6:15 p.m. Attendance: 158; reservations 170.

Minutes of the September 26 meeting were accepted as read by Secretary Griffin.

President Baker immediately went on to old business and specifically to discussion and vote on the questions raised by the questionnaire mailed to each member of HDMS by the Committee to Preserve the Rights of the Fellows of the MMS under the stimulus of the Middlesex East District Medical Society. These questions had been raised at the September meeting of the HDMS but were ruled to be new business at that time thereby necessitating prior consideration by the Executive Committee and recommendations therefrom at this meeting.

At its Oct. 17 meeting, the Executive Committee of HDMS voted that the Society as a whole should take a stand on each of the questions rather than make recommendations to individual members for appropriate action. Thereupon, each of the following propositions was considered and voted upon:

1. That all negotiations with third parties including the Welfare Commissioner be based only on the range of usual and prevailing fees.

2. That the Mass. Medical Society withdraw its approval of service benefit contracts and direct Blue Shield here-

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with to cease and desist from the sale or renewal of such contracts.

3. That the participating physician's agreement be revised to permit resignation with a 60-day notice, that it be renewed annually, and that medical services be furnished in accordance with the rules and regulations adopted by the corporation.

4. That Blue Shield furnish full benefits to subscribers who have covered medical services furnished by a non-participating physician.

5. That the Fellows of the Mass. Medical Society herewith withdraw their approval of Mass. Medical Service Corp. (Blue Shield) until resolutions two, three, and four are accomplished.

6. That the Council consist of councilors, only elected councilors may vote and hold office.

All of the preceding had been voted in the affirmative by the Executive Committee and were confirmed in the affirmative by the HDMS membership at this meeting. Moreover, upon recommendation of the Executive Committee, the membership voted its intention to participate in the Mass. Medicaid program if the latter's total payment structure is on the basis of usual and customary charges. Both Dr. Nickerson, President of MMS, and Mr. Ott, Commissioner of Public Welfare, are to be appropriately notified of HDMS's position in these matters.

In the matter of binding Councilors to the expressed majority opinion of the membership, the Executive Committee presented the following resolution: "If an opinion regarding a controversial matter has been clearly expressed as a majority opinion by the District Medical Society, it is expected that our councilors note and act accordingly at the Council meeting." Some objections were raised revolving about the principle that Councilors should not be hamstrung in their voting, particularly, should some mitigating information come to the fore during Council discussions clearly indicating continued commitment imprudent. In spite of these objections, the membership voted in the affirmative for this resolution.

In the matter pertaining to the manner of election of Councilors, this was referred to the By-laws Committee.

The meeting was then recessed from 6:40 p.m. until 8:40 p.m. for a social hour and collation. Upon resumption, President Baker introduced Dr. Donald A Nickerson, President of the MMS, who made a presentation updating the membership on the latest developments relative to Blue Shield problems and negotiations with the Mass. Dept. of Public Welfare.

The meeting was adjourned at 9:25 p.m.

* * *

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AN UPDATING ON PROBLEMS PERTAINING TO MASS. BLUE SHIELD AND MASS. MEDICAID

The following are highlights excerpted from an "off the cuff" updating report made by Dr. Donald A. Nickerson, President of the MMS, to the membership of the HDMS at the latter's regular meeting of December 5, 1967.

SERVICE BENEFIT CONTRACTS

In regard to the resolution adopted by the HDMS relative to the MMS withdrawing its approval of service benefit contracts and directing Blue Shield to cease and desist from selling or renewing such service benefit contracts, Dr. Nickerson pointed out that it was virtually impossible to invalidate instantly all service benefit contracts. Many contracts are written for a year and a few, for two years. In the latter instance, the largest group consists of some 30,000 employees of the Commonwealth of Mass. and this contract does not terminate until some time in 1969. Since the Mass. Commissioner of Insurance must approve each new contract written as well as any contract changes affecting subscriber rates or benefits, it is obvious that any change substantially increasing subscriber rates would not receive approval, especially while any contract is still in effect and when many organizations employing thousands of people are paying subscriptions to Blue Shield in whole or part as a negotiated fringe benefit. Hence, phasing out of service benefit contracts is the most prudent course. As each group contract expires, a new contract based on usual and customary prevailing fees for physician services can be offered for sale.

At its May meeting, the Council of the MMS voted that all Blue Shield service benefit contracts be phased out by January 1, 1970. The Board of Directors of Blue Shield voted at its meeting of October, 1967, to accept the principle of usual and customary prevailing fees and instructed its salesmen not to sell any contracts but on this basis. Moreover, there is evidence to believe that the Mass. Commissioner of Insurance will allow Blue Shield to sell these contracts from now on since so many people nationally are already so covered (i.e., Medicare) and a precedent has been set by allowing many corporations to so negotiate in their contracts with various unions (i.e., U.S. Steel, U.S. Rubber, and the automobile manufacturers). Dr. Nickerson further stated that the service benefit concept has stood the medical profession in good stead over the years as far as Beacon Hill and legislation were con-

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cerned. Blue Shield could always point to this concept and say that this was a public service justifying its tax exempt status as a voluntary, non-profit corporation.

PARTICIPATION AGREEMENTS

In regard to the resolution pertaining to the participating physician's agreement with Blue Shield being revised to permit resignation with a 60-day notice instead of a one year notice as required by the present enabling act and regulations, Dr. Nickerson stated that this would probably require Blue Shield to seek a change in the enabling act from the General Court of Mass. Opening up legislation might not eventuate in rules passed by a "somewhat hostile" group on Beacon Hill that would be advantageous to physicians. Moreover, if physicians were allowed to resign after 60 days notice but subscribers had a contract running for a year or more, how then would physicians be reimbursed? Currently, Blue Shield can pay nonparticipating physicians only for a "one shot" emergency ministration or for out-of-state physician's services when a subscriber is out-of-state. On the other hand, if a subscriber is paid for services rendered by a nonparticipating physician, then Blue Shield becomes only a physician's insurance company providing prepaid health insurance. In all probability, Blue Shield could lose its identity as a voluntary, non-profit, nontaxable corporation and a large number of subscribers along therewith.

WITHDRAWAL OF APPROVAL

The Fellows of the MMS can vote to withdraw their approval of the Mass. Medical Service, Inc., until all of the aforesaid are effected; however, it is questionable as to what effect this would have on Blue Shield since the latter is a duly established, independent corporation with its own Board of Directors. The only direct relationship between the MMS and Blue Shield really is the unique fact that all of the members of the Blue Shield's Board of Directors are elected by the voting members of the corporation, namely, the Executive Committee of the MMS's Council. In this sense, the MMS does control the destinies of Blue Shield by virtue of electing its Board of Directors. In addition, in an emergency situation, the voting members of the corporation could vote to dissolve Blue Shield. Therefore, Dr. Nickerson stated: "I am not sure that, if we voted disapproval of a program, it would have any effect except for some publicity."

COUNCIL COMPOSITION

The Statutes of 1802 and 1852 clearly state that the MMS Council shall consist only of councilors and that only elected councilors may vote and hold office. "There is no question that this is what has to be." All others, previously known as ex-officio councilors, will probably have to be called

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by some other term and may be allowed the right to voice but certainly not the right to vote unless duly elected by their respective district society. Legal counsel for MMS considers that, since each district elects a president and secretary, then the latter may be considered elected rather than ex-officio councilors as in the past with the right to voice and vote.

All the enabling statutes pertaining to the MMS are now under study by an ad hoc committee composed of the Society's Committee on Bylaws and Council Rules and five other members of the Council (2 from the Executive Committee) as appointed by President Nickerson. This committee is already at work with the objective of "coming up with suggestions as to how MMS may best function in today's modern society." Whether there will be changes recommended in the enabling legislation, in the councilor system, or in the whole set-up of running the Society is in the hands of this committee."

MASS. MEDICAID

In the policy making area for implementing the Mass. Medicaid program, there seems to be confusion in the minds of some physicians between the Mass. Dept. of Public Welfare's Advisory Board and the Governor's Advisory Committee under Title XIX. The former is an intradepartmental board composed of 15 members elected from within the Department and charged by statute to direct the Commissioner (Mr. Ott) in certain areas including payment for vendor services (i.e., physician services). There is only one physician on this Advisory Board — Dr. Count Gibson. The officers of MMS have been negotiating with Commissioner Ott and his Advisory Board for some time relative to reimbursing physicians on the basis of usual and customary prevailing fees. Pending establishment of some workable machinery to implement same, the MMS Council voted at its May meeting to negotiate on the basis of Blue Shield Plan B plus 30% since all available data pointed to this as being on the average in keeping with currently prevailing fees. Commissioner Ott and his Advisory Board have steadfastly not been willing to accept this Plan B plus 30% concept by claiming that sufficient information was not available to them to justify same and in spite of all the presentations by the MMS. Apparently Commissioner Ott is seeking a fixed fee schedule subject to some nebulous future renegotiations rather than a range of prevailing fees with built in flexibility for frequent renegotiations. Once a fixed fee schedule is adopted, there would be no flexibility built in to keep up with increased costs of living and increased costs of providing

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services by physicians. As the situation now stands, Commissioner Ott's Advisory Board has voted Plan B only. However, Dr. Count Gibson, a member of this Board, has been delegated to consult with representatives of the Governor's Advisory Committee under Title XIX and to report back with recommendations. Commissioner Ott and his Advisory Board feel a certain urgency to settle the matter for a variety of reasons but mainly because many physicians are not sure that they want to take care of Medicaid patients under the present fee structure along with its rank inequities to certain groups, namely, pediatricians, obstetricians, and internists.

On the other hand, the Governor's Advisory Committee under Title XIX, which was established about 1½ years ago and is composed of 20 members including 6 physicians, has voted on 3 separate occasions "firm and unequivocal" support for the principle that reimbursement to physicians be exactly as under Title XVIII — usual customary fees within the prevailing range.

Recent developments seem to indicate that a settlement will be made on the basis of Plan B plus 30% with appropriate modifications and additions being made to cover procedures not included in the Plan B schedule. However, if Commissioner Ott is reappointed in 1968, he still has some time to negotiate since Federal matching funds will not be cut off until January 1, 1969, when at least 2/3 of the physician providers of services must be participating in the program.

Whatever the settlement with the Mass. Dept. of Public Welfare, it will be only an interim measure. With the complete takeover of welfare administration by the Commonwealth and the concern over costs thereof, the Governor's Advisory Committee under Title XIX has recommended that the Mass. Dept. of Public Welfare negotiate with an insurance company to act as a carrier for the payment of fees for services rendered by physicians. A contract for same has already been written. Of the 3 eligible insurance companies approached, only Blue Shield has signified interest. Therefore, it is hoped that in the very near future "Medicare and Medicaid will be both under Blue Shield as far as the carrier is concerned and that under Blue Shield there will be comparable payments for comparable services under comparable circumstances."

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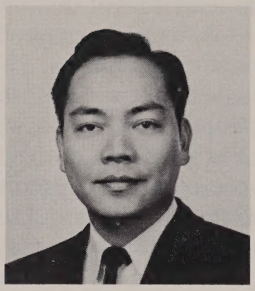

Dr. Asinas

Augusto G. Asinas, M.D. Office: 207 Elm Street, Holyoke, Mass. Born: Butuan City, Philippines, May 28, 1934. Medical School: University of Santo Tomas, College of Medicine, Santo Tomas, Manila, Philippines, 1957. Internship: Mercy Hospital, Springfield and Providence Hospital, Holyoke. Residency: New England Medical Center, Boston, Mass. Specialty: Neuro-Surgery.

Dr. Forbes

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Dr. Sexton

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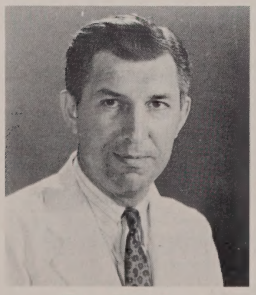

Dr. Smith

Lorne C. Smith, M.D. Office: 1767 Northampton St., Holyoke, Mass. Born: Lakewood, Ohio, April 22, 1928. Medical School: Western Reserve School of Medicine, Cleveland, Ohio, 1960. Internship: Presbyterian Hospital, New York City. Residency: Presbyterian Hospital, New York City. Specialty: General Surgery.

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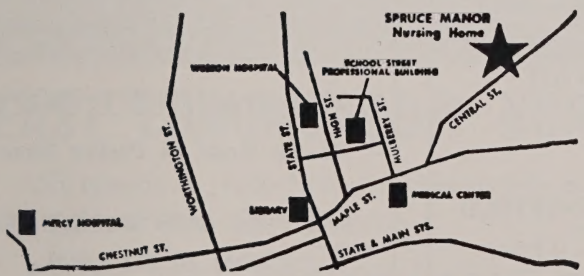

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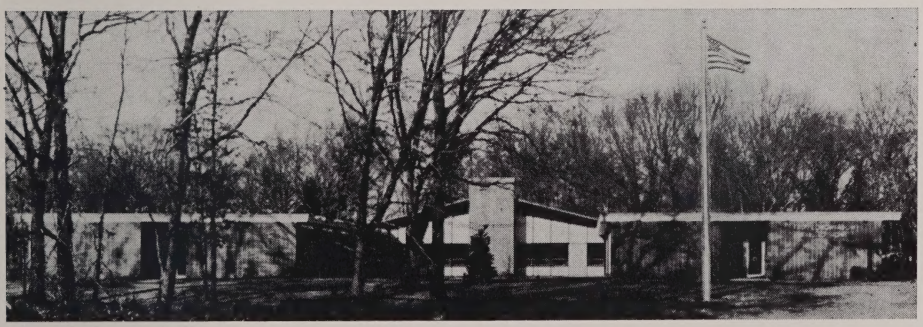

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